Medical History

Physician's Name and Number ______________________ Date of Last Physical ___________

Have you had any of the following? (Please check any that apply)

__ Heart Murmur
__ High Blood Pressure
__ Low Blood Pressure
__ Anemia/Blood Disorders
__ Artificial Joints
__ Radiation Treatment
__ Artificial Heart Valves
__ Diabetes
__ Respiratory Problems
__ Other Heart Problems
Describe ___________________________________

__ Epilepsy
__ Headaches
__ Hepatitis, Jaundice
__ Cancer/Chemotherapy
__ Psychiatric Care
__ Glaucoma
__ Liver Disease
__ Tuberculosis
__ Hemophilia
__ Asthma/Hay Fever

__ Special Diet
__ Mitral Valve Prolapse
__ Rheumatic Fever
__ Sinus Problems
__AIDS/HIV
__ Thyroid Disease
__ Stroke
__ Kidney Disease
__ Fainting

Have you ever had an allergic reaction to any foods, drugs, latex gloves or metals? If so, please describe ____

Have you had any unusual reactions to dental treatment or dental anesthetic? If so, please describe ____

Please list any current medications, which you are presently taking _______________________

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Are you currently under the care of a physician No __ Yes __ If so, for what? _______________

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Women – Do you suspect that you are currently pregnant? No __ Yes __

Are you presently nursing No__ Yes __

Is there anything else, which we should know about your medical history? _________________

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The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date __________ Patient Signature ________________ Doctor/Staff Signature _____________